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TOWARD THE PREVENTION OF MENTAL DISEASE

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This is an age when the prevention of disease is being stressed. The problem of the prevention of mental disease is obviously a most important medical responsibility. Many of us feel that mental hygiene is an important approach to such prevention.

To make clear what I mean by Mental Hygiene, I will quote from Groves and Blanchard: "Mental Hygiene represents a distinct purpose and viewpoint rather than a definite sphere of science. It cuts across many of the divisions that have resulted from the study of human conduct. Of these, psychiatry, psychology and sociology yield most to the accumulating fund of Mental Hygiene." Simplified a bit, Mental Hygiene, as I understand it, is a system of principles or rules, based on adequate experience, for preserving and increasing mental health.

In the past one hundred years we seem to have progressed from that early period where we viewed man's mental ill health as due to demoniacial possession, noxious vapours, or punishment by an all powerful Deity, to a more factual psycho-biological interpretation. During the century passed we have struggled to advance our understanding of the mind diseased on a rather narrow and irregular front. For a long time the "bete noir" was heredity. The sins of our fathers descended upon the children and thus we thought we understood all too easily why many personality changes occurred, why dementia praecox developed and why so many cases did not recover. After a time, careful observers and scientific thinkers realized that in a vast number of these cases heredity failed to give the true answer to many of the existing conditions. We witnessed many a mental disaster in which, as far as investigation could search, heredity did not offer any valid basis for the situation. As a result, we tended to lessen our interest in this approach and sought another simple solution. And this for a time was found, so we thought, in the environment. We became depressed because something in our environment depressed us—we became antisocial for the same reason—we developed Schizophrenia (for about this time the term Schizophrenia began to come into general use) because of conditions about us, and so another approach to the understanding of behavior problems was offered us; and for a considerable period the environmental factors were stressed and were said to account for a multitude of mal-adjustments. Gradually, we realized we were seeing many individuals brought up in essentially the same environment who reacted in very different ways, and when we witnessed a black sheep and an angel of the same sex, of the same age, growing up in the same environment, we were forced to face the fact that the environment was far from being the whole story. Therefore, again, we reviewed the problem of human behavior with a more critical eye.

It was about this time that workers in the field of mental medicine began to take cognizance of unconscious factors in our daily lives and to recognize that it was often what was within man that dictated his actions and his feelings. Thus, we came to that period in psychiatric thought when greater emphasis was placed upon an attempt to understand the inner yearnings, the strivings, the unconscious conflicts and the frustrations of our patients and to understand that the many things they did and said, or did not do and left unsaid, were the result of what was within the patient rather than being directed by what came from without.

Over six years ago, in a paper read at the first International Congress on Mental Hygiene, Doctor Frankwood E. Williams said: "Development of knowledge, facility, and technique—is of the greatest importance, if for no other reason than that it is a point at which we can attack and with some success cut into the vicious circle of events that continue to produce and reproduce results long recognized as undesirable. We are, after all, not in a position to create a world de novo, but must work

in the midst of life itself and of social situations. What is immediately important and practicable is determined, therefore, by what can actually be done, the various factors being what they are. Working on the basis that certain forces, personal and community, have an effect upon the development of the character and personality of the individual is important and practicable, for these things do have an influence, but the point I wish to make here is that perhaps after all, either for good or for bad, they do not have quite the influence we think, or, at least, that they should not and need not have quite the influence that they now have. My point is that really the life of the individual, in a very fundamental sense, is lived within himself; that nothing can hurt the individual from outside, or, for that matter, help him; that the only person who can hurt, or help, any individual is himself; that an individual for his hurt or help can respond only to those things to which he is capable of responding by reason of his own psychic economy.

An individual starts with a certain hereditary potentiality. Wrapped up in these potentialities are certain needs. Things happen to the individual in the very early days of his life, and needs and experience become formulated into problems. Problems seek solutions, but the solutions must be found in the midst of a constantly changing situation with experience piled upon experience. Later, when we come to study the individual in the clinic, the situation has become complicated, for we have to consider not only the original needs of the individual, but what has happened to these in the course of events—the solutions of problems the individual has attempted, the course of failure, partial success, and success, the defenses he has built up against outside forces, their failure, and results, or degree of success, and—more confusing than all and certainly of great importance—the counter-reactions of the individual against himself, the defenses he has built up against the forces within himself." This statement seems to me prophetic and to illustrate the keen insight and far-reaching vision of Doctor Williams, and I believe points the way to a most important period in our approach to the better understanding of mental mechanisms, and one which should be productive of a far deeper and wider understanding of mal-adjustments than we previously possessed.

I sincerely trust that although this method may fail to reveal for a long time to come *all* of the deep-seated inner strivings of man, we shall not for that reason believe it has failed and blithely pass on to other fields in our search for a better understanding of man and his conduct.

On one point at least we have all united: all behavior has an underlying cause. Medicine has always sought the cause of disease, and when it has been found our therapeutic efforts have always been stimulated, made more exact and proportionately more successful. This must be the principle constantly adhered to in mental medicine, if we are to develop the science and perfect the art. However, just a word of warning: in following new gods, are we always sure it is wise to discard the old? Often the illumination coming from the flame of the new altar lures us away from other shrines gleaming, at the moment, less brightly. Must we not continue to search in the field of genetics for a better understanding of biological sources of unstable or damaged material? Must we not endeavor to learn more about what we loosely refer to as predisposition? Just because we do not know enough about heredity to prognosticate which children in a family will be stable and which unstable does not release us from the duty of continuing our search with the hope that with the aid of the geneticist, the anthropologist, the embryologist and of the chemist we may yet learn some of the secrets of biological transmission.

Also, is there not much yet to be learned from environmental causes? I know that after a number of years of experience with behavior problems in the Bradley Home we have demonstrated that many serious disorders of behavior can be promptly, and at least temporarily, modified by removing the individual child from a bad environment and placing him in one in which the total environment, including the attitudes of those about the child, is constantly wholesome; and we ourselves witness all too often the effect of environment upon our own moods and our own thoughts. Therefore, in our future studies let us not neglect environment, but rather let us continue to study it with an ever increasing quantitative and qualitative analysis.

But, let us return for a moment to the central theme of the thought I want to leave with you—namely, that there is within the individual much of the determinant which directs behavior. We already have a large body of evidence which shows us that one of the many problems of mental medicine, namely, alcoholism, is often the result of the inner striving of man for security and a magnification of

the ego, and that it is only by better understanding of what alcohol represents in the needs of the individual that our treatment can be made more efficient. And this simple illustration we must all realize can be multiplied many times in the problems of drug addiction and various other so-called neurotic disorders, as well as in many psychoses.

We are witnessing today changes throughout the world that may cause a collapse of some of our civilizations. If this does happen new civilizations are bound to rise, and the hope for them I believe lies in a better and broader education of the individuals concerned—an education which begins in childhood and deals far more than has the past education with the problems that lie deep within us, so that future generations may be equipped with a better understanding of the emotional life, and with an increased knowledge of the domination of these inner forces. Added to this we must have certain fundamental philosophies which are satisfying to us which will be enduring and which will make for inherent strength rather than fatal weaknesses.

I will conclude with the expression of the hope that Mental Hygiene may not be too narrow and too one-sided but rather that it proceed in its search for the scientific foundation of the principles of heredity, and the application of these principles, when discovered, for the benefit of mankind; that we shall continue to urge upon society the understanding of constructive and destructive forces in environment; that we shall strive to eliminate malignant forces and to develop in society those elements which shall make the world a better and a happier place in which to live.

Along with these two disciplines in man's life, may we be ever mindful that our search for the ultimate good shall never fail to emphasize the need of sound scientific understanding of the inner life of each one of us, remembering that the inner life is made up of both biological and psychological factors. Our studies should go forward on a broad, cooperative, scientific front—never on a narrow, subjective quest. This is not a simple formula for the individual, rather is it a very exacting one, but few of the worthwhile problems of the world are simple and easy of solution. Therefore, to achieve one of the greatest needs of humanity—namely, to preserve mental health and to prevent mental ill health, we must be prepared to follow a long, complex and tedious pathway, ever realizing the wise saying of old, "Know the truth and the truth shall make you free."

THE NEW STATE HOSPITAL FOR MENTAL DISEASES

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Questions regarding the State Hospital for Mental Diseases which have been put to me, not only from the laity, but by members of the medical profession, as well, have indicated that there are few, even within the medical profession, who have any real conception of the functions, needs or future prospects of the Hospital. I am convinced that a more intimate knowledge of facts will be most beneficial to the Hospital and not without benefit to the members of the medical profession.

Judged by accepted standards as to the area requirements in a well planned and organized hospital for the mentally ill, the State Hospital for Mental Diseases was, prior to the beginning of the present building program, nearly one hundred per cent overcrowded. In other words, approximately 2400 patients were jammed into space originally intended for 1300. The Hospital had the distinction of being the second most crowded institution of its type in the United States. For many years suceeding superintendents of the State Hospital for Mental Diseases tried by other means to put before the public the situation at the Hospital, its seriously overcrowded state and the need for more space for patients and for increased facilities for treating them. Their efforts, except in a few isolated instances, proved fruitless until, in the summer of 1936, overcrowding had reached the point of saturation and it became necessary to curtail admissions, thus interfering with the ability of the people in the community to rid themselves of mentally sick persons. When this situation developed, the needs of the Hospital at last became apparent and with the whole hearted assistance of the medical profession, the Department of Public Welfare and the Superintendent were able to accomplish what years of effort on the part of the superintendents alone had been unable to accomplish, make the people of the state see that immediate and drastic measures were necessary to overcome an intolerable situation. This culminated in approval by the voters of the state, of the bond issue of August 6, 1934, which permitted the erection of new and the remodeling of old buildings at the State Hospital.

The program includes the erection of eighteen buildings, at a cost of approximately $5,000,000, of

which the Federal Government has furnished, or will furnish, forty-five per cent of the funds, the State, fifty-five per cent.

The patient capacity of the entire hospital plant when all new buildings are ready for occupancy will be approximately three thousand. It now appears that the Hospital population will not reach the three thousand mark until 1941 or 1942.

Perhaps the key building in the new State Hospital organization will be the Psychiatric Clinic. This is a building of one hundred and twenty bed capacity, with six wards of twenty beds each. Its functions will be the treatment of cases of mental illness which are regarded as possibly recoverable. If present plans materialize these patients will be provided with comfortable, pleasant surroundings. There will be adequate medical and nursing personnel, which will make it possible for patients to receive intensive psychiatric treatment, provided in few public institutions for the mentally ill. The building will contain facilities for the various types of therapy which have been found to be of value in psychiatric treatment, most important of which is individual attention to the patients' problems by trained psychiatrists. The building is so constructed as to make it possible for it to function as a unit and so located as to isolate it from parts of the Hospital which are devoted largely to the care of those suffering from chronic mental ailments. The patients who are suffering from mild mental ailments and those cases in which the prognosis is regarded as favorable will not be obliged to rub elbows with chronic cases as at present. It is planned to admit to the Psychiatric Clinic a greater number of patients who will come on a voluntary basis, to admit not only those persons who are suffering from benign psychoses but those who are in the incipient stages of more malignant psychoses, in order that they may have early treatment as a preventive measure. There are those who feel that a department of the type of the Psychiatric Clinic will add greatly to the expense of the care of the mentally ill in the state and that the people should not be burdened with this expense, since there are private institutions which possess all the facilities which the Psychiatric Clinic will possess. It may be said, however, that the facilities of such private institutions are not always available to the class of patients who come to the State Hospital for Mental Diseases. It is not intended that the new Psychiatric Clinic will provide treatment for those persons who are in a position to afford treatment in private institutions. The Psychiatric Clinic will provide more adequate treatment for those of the social group which the State Hospital now serves. Considering the situation from the standpoint of economy alone, if, by treating a patient early and intensively, his becoming a permanent hospital resident may be avoided, economies are bound to be effected. Since it costs the State approximately $6.00 per week, or $325 per year, to maintain a patient at the State Hospital for Mental Diseases, it will require the discharge, rather than the permanent hospitalization, of only a few such cases to make the Psychiatric Clinic worth while from the standpoint of economy alone even though the expense of giving the intensive treatment may be a little greater than the present cost.

A function which the limited facilities of the State Hospital have hitherto made it difficult to carry out, but which it is hoped may be developed in connection with the new Psychiatric Clinic, is that of teaching the younger members of the medical profession who may be interested in psychiatry. The Hospital has for several years been among those approved by the Council of the American Medical Association for residencies in psychiatry. The Psychiatric Clinic will add greatly to the facilities of the Hospital for the training of residents. It is hoped that members of the medical profession of the state will make use of the additional local source of psychiatric information which the Psychiatric Clinic will provide.

Second only to the Psychiatric Clinic building in its importance in the State Hospital's building program and a valuable adjunct to it will be the new Medical Building, which is being erected at a cost of approximately $500,000. This building will be a general hospital unit for the care of the physical ailments which naturally arise in the care of three thousand patients who are mentally ill and approximately four hundred employees of the Hospital. It is a four story brick structure. On the fourth floor will be an operating suite with two major operating rooms and accessory units constructed and equipped in accordance with the most modern ideas of hospital construction, artificially lighted and air-conditioned. On the second and third floors will be wards for patients, with all necessary equipment including special facilities for isolation and open air solaria. On the first floor, in addition to office and admitting facilities, there will be an eighteen-bed ward for employees. Hitherto employees of the Hospital received medical

care in improvised quarters off the wards. The new ward for employees will be fully equipped and furnished and in every respect adequate.

One wing of the first floor will house a number of special departments: a minor surgery; a pharmacy; a dental office and laboratory; chemotherapy room; eye, ear, nose and throat examining room; X-ray department; physiotherapy department. One wing of the basement of the building will be devoted to facilities for the Nurses' Training School: library, classrooms, diet and scientific laboratories, which will render the facilities for training nurses comparable with those of any general hospital in Rhode Island. In the basement there will also be a well equipped modern kitchen, designed to care for the needs of five hundrd and fifty patients. This basement is connected by tunnels with the new building for the tuberculous and the old Reception Building, which will be used to house senile patients. The building for the tuberculous and the building for senile patients will be administered from the Medical Building.

The Medical Building will be conducted in every respect as a general hospital. In charge of it will be a physician well trained in general medicine and with psychiatric training as well, a consideration which is regarded as important since he will be dealing with the mentally ill. He and his assistants will be relieved of all psychiatric duties and will devote their full time to the physical needs of the patients. All medical, surgical and other special activities will be concentrated in this building. Not only will those acutely ill with physical diseases be treated here but special medical studies of those not acutely ill will be performed, studies which are often necessary in investigating the background of mental diseases. Not only will those from the general wards receive care in the Medical Building, but those from the Psychiatric Clinic as well. The Hospital will, therefore, have an intramural consultation service which, it is hoped, may be augmented by a staff of competent medical specialists from the community. To those of the medical profession who have served on the consulting staff of the Hospital the need for a centralized department for the treatment of organic diseases has long been apparent. It is the hope of the resident medical staff of the Hospital that by offering better facilities for its consultants the latter will be more inclined to give their services and will stand to gain more from their association in a consulting capacity with the Hospital than they have in the past. It should be stressed that since the Hospital is designed for the care of the mentally ill, psychiatric treatment is of prime importance. It is thought, however, that such treatment will be rendered more satisfactory as a result of the new medical unit, since maintenance of physical health is regarded as a most important factor in maintaining the mental health of patients.

Operated in close conjunction with the medical building will be the new building for the tuberculous, with a capacity of ninety patients. It is thought that this will be sufficient to take care of the present needs of the Hospital and it is hoped that, as a result of the better facilities for isolation and treatment of the tuberculous, the incidence of this disease will be appreciably lowered. It is hoped eventually to apply all the modern methods for the treatment of the tuberculous in vogue in the special hospitals for the treatment of this disease.

A special feature of the building program which is considered of almost equal value and importance to the Hospital as the medical building and the building for the tuberculous is the construction of two buildings for disturbed patients, one for men and one for women, each having a capacity of two hundred and forty beds. These buildings will be complete units in themselves, set apart from other buildings so that the disturbed patients will not annoy or be annoyed by the remainder of the patients. In each building for the disturbed there will be six wards with a capacity of forty patients each. This will make possible the segregation of the various types of patients, thus to a large extent eliminating the contamination of one group with the particularly vicious tendencies of another group. It will make possible the application of special methods of treatment to groups requiring such treatment. In these buildings it will be possible to apply to those among the disturbed patients who are not entirely lacking in social standards, those who have preserved some of the better aspects of their personalities, special methods of treatment designed to rehabilitate them. At least it will be possible for such patients to remain free from the sordid influences of the more deteriorated patients and thus be saved from permanent isolation in hospitals for the mentally ill. The buildings will have excellent facilities for recreation, for hydrotherapy and eventually for occupational therapy, which have been entirely lacking in the present inadequate quarters. The buildings will contain complete dining facilities which will further permit the isolation

of the so-called better class of patients from the more deteriorated groups.

The Hospital will thus have the best of accommodations for those patients who are suffering from recently developed and mild mental disorders and who are regarded as recoverable, on the one hand, and on the other, for those suffering from the more malignant and severe forms of mental disease, from among whom a few may be salvaged. The wide separation of these groups should work out to the advantage of both classes of patients.

There is a middle group which constitutes the greatest percentage of the patients—those who are suffering from chronic mental ailments and probably will not recover but who, if given the advantage of proper segregation and treatment, might be retrained and resocialized, perhaps returned to the community to become useful citizens. The cases of these patients are by no means regarded as hopeless. Although it may not be possible for all of them to be returned to the community, the new facilities will permit these people to live in comparative comfort in the Hospital. It is this group which does a large portion of the work necessary to permit the various departments of the Hospital to function. For these patients, in addition to old buildings, will be provided two continued treatment buildings for women, with a combined capacity of two hundred and forty, a remodeled building for women with a capacity of forty, a continued treatment building for men with a capacity of two hundred and fifty, a remodeled treatment building for men, with a capacity of one hundred and sixty. These buildings contain no special facilities for treatment, but are constructed with a view to sanitation and the comfort of patients. In them will be located facilities for recreation which will relieve the humdrum course of ward life. There will be a number of minor facilities for occupational therapy and hospital industries.

There are certain other features of the program which, though not of direct medical or psychiatric significance, are important in the administration of the Hospital and are necessary adjuncts to the ward buildings. Without them the Hospital could not function at the high level which the other new buildings will make possible.

There will be a Chapel and Auditorium Building with a seating capacity of twelve hundred and twenty. This will provide facilities for religious services and recreation and will replace an old hall located on the second floor, which was large enough to accommodate only a small percentage of the patients and constituted a serious fire hazard.

A new Administration Building is to replace an old suite of offices occupying a portion of a building, the rest of which was devoted to living quarters for employees. Removal of the administrative quarters from this building makes it possible to convert the space which they occupied into a cafeteria for employees, who formerly were crowded into quarters so small that it necessitated the serving of three shifts at each meal and which could not be adapted to the increase in personnel occasioned by the growth of the Hospital.

The building program includes the replacement in the main kitchen of antiquated, broken down and generally inadequate equipment with new equipment, and the remodeling and re-equipping of the patients' main dining-room to accommodate it to cafeteria service. This work was a matter of absolute necessity since with the old type of service the dining-room had become much too small and could not be made to meet the needs of the increased population of the Hospital. The institution of cafeteria service for patients will not only make it possible to serve all the patients, but it will give them a more pleasant environment in which to dine, a greater choice of food and may be operated much more economically than the old type of service. As an adjunct to the kitchen and dining-room service, a new refrigerating plant has been installed.

In order that the Hospital might expand and function properly it was necessary to furnish adequate living quarters for employees. To meet this need there have been constructed two new dormitories for nurses and other employees, each with a capacity of one hundred and forty persons, a staff house for single physicians and officers of the Hospital, and five cottages for married physicians.

The remaining project in the building program was the removal of the Dairy Barn from its location in the midst of ward buildings to a new site apart from the remainder of the Hospital. To it was added a dairy wing which not only increased the capacity of the barn so that most of the milk used in the Hospital might be produced, but made it possible to produce this milk under sanitary conditions comparable to those of modern dairies in the community.

Finally, there have been constructed several new garages, storage buildings and sheds, each one in itself of minor importance, but contributing to the efficient administration of the Hospital.

These new buildings will render the Hospital a well equipped, adequate institution, equal to any of its type in the United States. With such a plant, provided funds with which to operate it are furnished, there seems to be no reason why the standards of psychiatric care accorded to those in the State of Rhode Island should not be equal to those of any other state. That such standards be maintained is largely the problem of the medical staff of the Hospital. If it has the understanding cooperation of the medical profession, I am sure that such standards will be maintained.

PRACTICAL MANAGEMENT OF CONVULSIVE DISORDERS IN CHILDHOOD

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One of the more common medical emergencies met by the pediatrician and general practitioner is the occurrence of convulsions in a child. So common an emergency merits the attention of medical men, particularly as scientific developments within the past few years have placed at our disposal new diagnostic and therapeutic facilities. To consider this subject completely is far beyond the scope of a brief article, but a short discussion of the subject in the light of up-to-date concepts, emphasizing the practical aspects of treatment, would appear to be timely. Detailed discussions are available in the various bibliographical references.

The viewpoint that a convulsion is essentially the symptom of an underlying pathological condition and is not in itself a disease is gradually becoming adopted by most medical men who are familiar with the subject.[1] The occurrence of a convulsion in a child is no more diagnostic of a specific disease than is the occurrence of a cough. The old but vague concept of epilepsy as a disease entity characterized by repeated severe convulsions and eventual mental impairment would seem to serve little purpose at the present time except to discourage the patient and his parents. Much more to the point is the concept that if convulsions occur a definite and systematic search must be made for the cause of this symptom, and steps must always be taken to prevent its recurrence.[2]

There is no need to describe here the classical manifestations of a convulsive disorder such as grand mal and petit mal seizures and the various equivalents. The fact that a particular type of personality is very frequently seen in children who are subject to convulsions must always be recognized. Such children are often irritable, self-centered, and their behavior varies without obvious reason from day to day. In school, arithmetic is characteristically the worst subject. Intelligence may be entirely normal, but frequently where severe convulsions have occurred often over long periods of time, intelligence may appear to be impaired. In such cases eventual control of the convulsions rarely restores intelligence, and, therefore, every effort should be made to bring the condition under control as early as possible.

Etiology

In spite of scientific progress a large percentage of convulsive disorders must still be regarded as of unknown etiology. Of course, efforts should be made to produce evidence of brain injury or any metabolic disturbance which might be susceptible to treatment, and thus remove the cause of the condition. Mechanical trauma, with resulting localized scar or depressed bone fragment, or the damage which comes with an expanding intracranial lesion, such as a tumor, may definitely cause convulsions, and often may be treated successfully surgically.[3] Convulsions may also occur secondary to toxic conditions, such as lead poisoning,[4] hypoglycemia,[5] uremia,[6] etc., all of which require medical treatment, and the practitioner who neglects to search for definite causes and merely gives palliative treatment is not fulfilling his obligations.

Clinical Study of the Patient

An adequate history and physical examination is presupposed in the hands of any competent medical man. In the history definite inquiries as to whether there has been any evidence of injury to the brain either at the time of birth or subsequently in association with mechanical accidents or illness, such as encephalitis, are important. Many contagious diseases and asphyxiating conditions in infancy, such as pneumonia or severe whooping cough, may be accompanied by encephalitis resulting in brain damage.[7] The circumstances surrounding seizures should also be investigated as apparently some attacks are precipitated by emotional trauma,[8] some are said to be allergic in origin,[9] and some may not be real convulsions at all. Such manifestations as tetany, breath holding spells or temper tantrums should be ruled out.

The physical examination should particularly aim at producing evidence of any localized intracranial lesion, such as might be demonstrated by inequality in reflexes, sensation, or disturbances of the eye-grounds.[10] In questionable cases a neurological consultation is doubtless advisable since localized brain lesions may definitely be susceptible to surgical treatment. Blood chemical examination may be useful in ruling out hypoglycemia, renal insufficiency, or low calcium tetany in young infants. An X-ray of the skull for evidence of depressed fracture or signs of increased intracranial pressure is essential in most patients. The pneumo-encephalogram,[11] although now in wide use and a safe procedure in experienced hands, serves its main purpose in confirming evidence picked up on physical and neurological examinations. Many competent workers are beginning to feel that it is not essential except in this light.

In children it is sometimes difficult to distinguish between convulsions and other conditions simulating them, such as have been mentioned above. The pitressin test, wherein convulsions are induced in susceptible children by temporarily producing a positive water balance, is a useful but drastic form of hospital diagnostic procedure.[12] The use of convulsive drugs, such as cardiazol or metrazol which in small doses will produce seizures in children who are predisposed to them, is also a fairly radical form of diagnostic measure.[13] The electro-encephalogram, now in its developmental stages, yields definite evidence of the presence of a convulsive disorder without upsetting the patient and will doubtless come into clinical use for this purpose.[14]

Treatment

There are several aspects to the treatment of convulsive disorders which for convenience will be itemized as follows.

Surgical: If there is evidence that a localized intracranial lesion is responsible for the convulsions, the patient should be referred to one of the recognized neurosurgical clinics for complete investigation and possible operation. Such investigation and treatment is often astonishingly effective in experienced hands. Suitable cases are fairly rare and their radical treatment should not be attempted by the average surgeon except as a measure of last resort.

Medical: The physician is frequently called by an excited parent for advice as to home remedies in the treatment of a convulsion. Since most attacks subside spontaneously without treatment the family may well be advised to leave the child alone or place him on a bed. If it appears wise to give them something actually to do an enema can do no harm, occasionally relieves constipation, and satisfies the family. The use of mouth gags, hot tubs, etc., may produce burns or mechanical damage in indiscreet hands, and as a general thing are not advisable.

If seizures are prolonged or repeated, the physician himself should probably see the child. In his hands, inhalation anesthesia with ether or chloroform, if available, is probably the most rapidly efficacious form of treatment. If they are not available and the case is urgent, intravenous drugs, particularly sodium pentobarbital[15] in doses of 1 to 3 grains or paraldehyde[16] in doses of 1 or 2 cc., may be given. Intravenous drugs should be given very slowly and paraldehyde will be painful and cause a slough if it gets outside the vein.

In less urgent cases the use of powerful, rapidly acting hypnotics, such as chloral hydrate in doses of 10 to 15 grains or paraldehyde in 4 to 6 dram doses by mouth or by rectum in older children with correspondingly smaller doses in infants, is very satisfactory. Naturally doses larger than the usual sedative amount are required.

Where no specific cause has been ascertained as the focus of treatment, empirical measures to control convulsive attacks must be used. Fortunately, they are fairly efficient. Phenobarbital, in doses of ¼ to ½ grain three times a day even in small children, may be kept up for long periods of time, and is the most popular form of treatment in this country.[17] Sodium bromide or mixed bromides in doses of 10 to 20 grains three times a day is more popular elsewhere, although their salty taste and larger dosage sometimes make administration difficult for children.[18] Both of these drugs may produce skin rashes in which case a change should be made. If large maintenance doses of sedatives are necessary to control the convulsions but are accompanied by somnolence, caffeine citrate in 3 grain doses once to three times daily may also be used.

The ketogenic diet has within the past few years been a popular and effective form of treatment in the hands of pediatricians.[19] It requires careful measurement of the ingredients to assure sufficient balance of fat as opposed to carbohydrate and protein, to produce definite ketosis. It can be used in the home only under constant supervision. Complete understanding of its mechanism and administration by the physician is necessary. Certain of the ingredients of this diet are expensive and since it is troublesome to prepare and disagreeable to take,

it should not be prescribed at random. If effective it should be maintained for at least six months after the occurrence of the last seizure. Dehydration diets,[20] although effective in adults, require the cooperation of the patient and are, therefore, not adaptable for small children. Except in unusual cases, there is no good reason for the special dietary treatment of children who have convulsions except under one of the above regimes.

Environmental: All observers of convulsive disorders have noted that mental upsets or disturbance may precipitate occasional convulsions in susceptible people.[21] In general, it is wise to have children live as busy, happy, and constructive a life as possible in spite of their handicap, and calm, matter-of-fact handling of the patient by adults is some assurance of improvement.

Summary

The frequency of convulsions in childhood render their consideration important for the pediatrician and general practitioner. A search should always be made for the underlying cause, and the seizures should always be considered symptoms of some disorder. There are a number of definitely accepted forms of treatment, both for chronic and emergency use, some of which are available to any practitioner and some of which should be attempted only in the most experienced hands. No prognosis should be given without thorough investigation and the trial of accepted forms of treatment. The parents should always be given as clear an explanation of their child's disorder as possible.

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NEGLECT OF ELEMENTARY BODY FUNCTIONS — A SOURCE OF PERSONALITY MALADJUSTMENT

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The growing recognition of psychiatry as a part of general medicine has led to an increasing awareness of psychogenic factors in the production of physical complaints, even in such predominantly somatic diseases as arthritis and gastric ulcer. Psychiatry, on the other hand, is becoming increasingly aware of the need and importance of applying physiological knowledge in the treatment of psychiatric conditions or so-called nervous disorders.

Neglect of simple physiological fundamentals such as adequate rest, relaxation, nutrition and the like, may, if continued over a sufficiently long period of time, be reflected in the individual's personality adjustment, his overt behavior, and his subjective feeling of well being.

The symptoms resulting from this neglect frequently lead the patient to seek aid from his family

physician. If the latter is aware of the underlying cause of these complaints, he is in a position to afford the patient great relief and at the same time to prevent the development of what may become a maladjustment of the life pattern of considerable severity. The following two cases illustrate many aspects of these problems and have been selected because of the serious import of the symptoms.

C. L., eighteen, was referred by his family physician because of nervousness, restlessness and violent outbursts of temper. On several occasions he had run away from home and during one of these escapades had a period of amnesia.

His family and past history were not relevant. Around the early part of 1937, it was noticed that he seemed fidgety and restless. Once on slight provocation he violently attacked his brother, choked and bit him. The next day he disappeared from home and was gone for three weeks. His family found later that he had gone to relatives in Maryland. On his return home he went back to work and continued working until the end of April, when he suddenly quit his job. He then hitched-hiked to Florida, and was away from home for three weeks. While on this trip he worked as a golf caddy intermittently, on some occasions going as long as three days with nothing to eat. After returning to Providence he secured a job as a truck driver, but kept it for less than a week, giving it up because he felt irritable and exhausted. Again he hitch-hiked to North Carolina, eating irregularly, and on one occasion, for a six-day period, ate nothing more than a cup of coffee and a doughnut. His head began to throb, he felt quite weak and his memory went blank. He found himself in Baltimore, Md., with no remembrance as to how he got there. Some relatives started him on his way home. En route he had another memory lapse, finding himself beside the road outside of New London, Conn., with no realization of how he had arrived there from New Jersey. He finally reached home, where it was noticed that he was very irritable. He lost his temper easily and was quite argumentative with his brothers and sisters. Everything annoyed him. He complained there was something wrong with his head and appeared quite withdrawn, paced the floor and felt that he was losing his mind.

The patient, when first seen on July 6th, was an immature-looking boy, rather tense and ill-at-ease, who talked freely and was able to give a coherent account of his wanderings. Brief conversation with him elicited several important factors. At the time he had been working at the mill, his working hours were from seven A. M. to three P. M. He would then spend the remainder of the afternoon loitering around a pool room. After going home for supper, "his real day would begin." With a chum he would meet some girls and go riding, dancing or to the movies. During the course of the evening, he would drink seven or eight glasses of beer. Three or four times a week he would be slightly intoxicated. He did not get to bed until one or two o'clock in the morning, and would arise at five in order to go to work. He took no exercise and would loiter on a street corner for fifteen minutes until he could hitch a ride rather than walk a block. After a time, with this rigorous living, he began to feel run down. At work, towards nine or ten A. M., he would feel sleepy and begin to make mistakes. Reprimands from his foreman accentuated his irritability. As time went on he felt worse and worse until he finally quit his job.

The first interview also revealed some concern over masturbation. His father had warned him that this practice would "rot his brain," and the patient was attributing his feelings of malaise to this cause. As he showed some tenseness and emotional disturbance while discussing sexual matters, he was encouraged to speak frankly on this topic, whereupon he mentioned that he had been over-stimulated with no possibility of relief in his companionship with one particular girl. Consequently he had relieved his tension by masturbation and sporadic illicit sexual contacts, concerning which he had had numerous conflicts. After this discussion of the sexual difficulties of his life, the patient appeared much more at ease. As the first step towards treatment, the necessity for a simple regime of living was outlined to him. Since he had trouble falling asleep, he was directed to take a warm, relaxing tub at bedtime. He was instructed to be in bed by ten o'clock at night and sleep until seven. As he was not working it was outlined to him that he could obtain some outdoor exercise daily. He was also advised to keep occupied and not let his mind dwell on sexual matters. He promised to refrain from alcoholic indulgence.

Some improvement was noted when he returned to the clinic a week later. He stated that he had been following the physician's advice and was getting on well. Two weeks later he appeared in very good condition. He came in with a sprightly step, seemed quite happy and at ease. He commented on his ferocious appetite and mentioned

that he had gained four pounds during the week. He was spending most of the day bicycling and swimming. At this time he was again reassured concerning masturbation. He stated that he was now able to control the habit. On his fourth visit he was slightly apprehensive because he had masturbated once but was readily reassured.

The patient was not seen again until the middle of September. At this time his weight had increased three pounds more. He had spent the latter part of the summer vacationing at a camp and appeared to be in very good health, stated that he felt fine. He had obtained a job, which he liked, earning around $15.00 a week, and he no longer felt unduly tired. He was getting eight or nine hours' sleep, was moderate in his recreation, and had no worries. He felt that he was much better. At the last report the patient has continued to do well, is making a good adjustment to his job, and feels quite fit.

E. H., a twenty-six year old shoe salesman, was referred to the clinic because of "incipient mental changes suggestive of early dementia praecox."

Two months before, he had given up the position which he had held for five years, because he could not sleep, was unable to concentrate, felt tired and restless, and had no confidence in himself. Conversation with him disclosed that for over a year, in addition to working from nine to six-thirty, he had been attending night school four nights a week and had been seeing his fiancee every evening. He lived some distance from his place of work so that he had been averaging around five hours of sleep nightly and had had no time for exercise. His appetite was very poor and he had been feeling "quite run down." The breaking of his engagement aggravated his symptoms.

After giving up his job, he spent his time at his home in the suburbs occupying himself by chopping wood, caring for the lawn and fences and with other outdoor tasks. Soon he was sleeping nine hours, his appetite improved and he felt considerably better. By the time he came to the clinic he felt quite well and had regained full confidence in himself. As the regime he had worked out for himself seemed satisfactory he was encouraged to continue with it.

Two weeks later he felt physically well but still lacked confidence. He showed a tendency to indulge too strenuously in his outdoor tasks, so that some days he felt very tired, and he had also resumed attendance at night school. The necessity of moderation in activity and adequate relaxation was stressed to him and he was encouraged to return to his work. When last seen he had resumed his work. He stated that he felt quite well and had no further complaints.

Physiological excesses, so impairing the body as to prevent normal functioning, may be expressed not only in terms of dysfunction of that particular system whose needs have been neglected, but also in other functioning systems and even in that functioning of the organism as a whole which we recognize colloquially as personality.

A knowledge of normal physiological functioning is more valuable to the physician than is recognized in our current medical teaching, oriented more in terms of disease than in terms of health. With respect to these cases, normal functioning of nutrition, elimination, reproduction, sleep, and the ratio of work and play becomes significant. It is imperative to recognize the body's need of food, of regularity and adequacy of same, of the significance of proper mastication. With their knowledge of the physiology of nutrition, physicians are in a position to instruct patients in the art of eating. Similarly, satisfactory elimination is dependent not only on adequate nutrition and digestion, but also on awareness of normal physiological activity. The peristaltic activity that normally occurs in the lower bowel shortly after eating, combined with the sensation of distention of the rectum, constitutes the ordinary physiological signal for defecation; and unless the sensation is recognized and attended to, dysfunction results.

Many and all of us at times begrudge the time we must spend in sleeping. Failure to recognize the fact that obtaining adequate sleep is part of our job of living a healthy life, results in dysfunction. Bed-time is not a time to indulge oneself in dreams, emotional tangles, personal worries and the like, but to rest a physiologically tired body.

To comment to biologically trained individuals on the need of the proper ratio of work and play may seem trite. This may incline some of us to disregard the importance of elementary physiological requirements in coping with the symptomatology patients present. Activities which demand a great deal of attention and physical exertion evidently do not meet the recreational needs of a person whose daily work makes similar demands. Even more important, the individual has to recognize that he needs both work and play—he cannot afford to count the hours of work as lost, and begin his recreation as if he had the whole day ahead of him.

The protean symptoms arising from inattention to physiological needs may be detected by careful inquiry about the patients' habits and attitudes. This presupposes that the physician is able to evaluate complaints in terms of the individual as a whole, as well as in terms of organs and systems. Having obtained a history of poor physiological habits, confirmation of the diagnosis comes in the therapeutic test.

Treatment consists largely of explanation and education with respect to the elementary physiological needs and facts of the body. Patients are so frequently and promptly relieved that in our experience they adhere faithfully to the prescription. However, it may occur that with relief in symptoms, they revert to old habits. Therefore, adequate follow-up should be carried out until it is certainly established that the new habits have become firmly ingrained. Such drugs as sedatives and carthartics should be avoided, as they merely delay the individual's acceptance of the responsibility for attending to his physiological needs.

Response to such treatment is almost immediate. In the event results are not achieved within two to three weeks' time, in the face of faithful adherence to the prescription, the diagnosis should be suspected and more specialized assistance sought.

Summary

Failure to observe the fundamental physiological requirements of the body may contribute to the development of personality maladjustments. Awareness and correction of these physiological abuses often alleviate symptoms manifested at the personality level and prevent the development of more malignant maladaption.

INSULIN SHOCK TREATMENT IN SCHIZOPHRENIA

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Insulin for the treatment of schizophrenia has been tried with a group of selected patients in the Psychiatric Department of the Charles V. Chapin Hospital following reports from various sources as to its value. Manfred Sakel of Vienna, originator of the treatment, states, "I believe from what I have seen that it promises success." Isabel G. H. Wilson in a survey remarks, "The degree of response to be expected can not be clinically prophesied in any case or group of cases. The method certainly merits ample clinical trial." Joseph Wortis of Bellevue Hospital says, "The percentage of remissions is three or four times better than the percentage of spontaneous remissions we would expect without treatment." Bernard Glueck, also of New York, makes the statement, "The hypoglycemic therapy offers a more promising approach to the problem of schizophrenia than anything we have hitherto had at our disposal." D. Ewen Cameron of the Worcester State Hospital adds, "Our findings have demonstrated that insulin does produce amelioration in the majority of cases."

Nearly all of the patients in this series have been adolescents or in their early twenties. In most instances, they have been mentally ill for a short time and have not had previous attacks of mental disease. Before treatment was considered, each patient's physical condition was carefully investigated and had to be excellent. The mental status was taken before the treatment was begun, carefully observed during the treatment and at its completion, and was followed at regular intervals thereafter.

Regular insulin was used in preference to Protamine insulin and the initial dose was 5 or 10 units. This amount was increased daily by 5 or 10 units until the desired hypoglycemic reaction was obtained. The dose necessary to produce the reaction is variable; it may be 35 units for one patient and 200 units for another. The insulin was administered every day except Sunday and at the same time each day. It was given to the patients in this group at six or seven o'clock in the morning. They were kept in bed from that time until taken out of shock with food or sugar within five hours after the insulin had been administered. In a few cases, six hours had elapsed before the shock was terminated, without ill effects.

In the beginning, 35 hypoglycemic reactions were considered sufficient to effect any improvement thought possible. This number has now been increased to 50. Observations made during this small series lead to the belief that benefit, if any, is apparent during the first 15 reactions. In several patients the treatment had been stopped before the completion of the desired number of reactions, the chief reason being severe convulsions. In some cases a rest period of from several days to several weeks

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had elapsed before the treatment was resumed.

The symptoms of hypoglycemia are well known from experience with diabetes. There are some symptoms indicative of cerebral irritability which appear more serious, chief of which are convulsions, restless behavior and tossing about in bed. During the hypoglycemic shock some patients are incontinent of urine while others are not. A rapid gain in weight occurs in most patients during the course of insulin therapy.

The individual daily reaction was stopped by the administration of sugar by mouth, through the stomach tube or intravenously. Response was seen within five to fifteen minutes if the sugar was given by mouth or tube feeding, and almost immediately if intravenous glucose was used. After the desired number of insulin reactions, the course of treatment was tapered off with smaller and smaller doses of insulin.

In the Psychiatric Department of the Charles V. Chapin Hospital, sixteen schizophrenic patients have been treated with insulin. Six of this number were probably of the catatonic type; six were classified as paranoid; three were of the simple type and one was hebephrenic. Four patients are under treatment at the present time. Of the remaining twelve, eight have been sent home and four have been committed to the State Hospital for Mental Diseases. One of those sent home has since returned to the hospital and will eventually be committed to the State Hospital. Another has shown symptoms since discharge which indicate that he will require further institutional care. From this group it may be said that six have definitely improved and six are unimproved. None have become worse as a result of the treatment.

The six improved cases are briefly presented:

Case 1. Upon admission to the hospital, an eighteen-year-old girl showed religious tendencies, had persecutory ideas, took no interest in her personal appearance and was difficult to manage. She was preoccupied and silly and at times profane. She had visual and auditory hallucinations, was incoherent, illogical and irrelevant in her speech and refused to eat. Her judgment was poor and she had no insight into her condition. Her weight on admission was 103 pounds.

At the age of sixteen she left school when in the eighth grade. Psychological testing in the hospital revealed an I.Q. of 73.

Insulin treatment consisted of 46 hypoglycemic shocks. The average dose of insulin required to produce shock was 50 units. During shock her temperature was low, usually 93-95. Pulse was slow at times, and at other times rapid. She perspired profusely, was salivated and occasionally voided and defecated in bed. Her body was cold and her limbs became rigid, then relaxed. Inability to swallow was observed as well as hyperactive reflexes, ankle clonus and muscular twitching of the entire body. On at least four occasions there were definite generalized convulsions. She developed chills when coming out of shock and vomited during the early part of her course of treatment.

After treatment the girl showed marked improvement. She still seemed slightly preoccupied and seclusive, but kept herself neat and clean. She was pleasant, got along well with the other patients, showed appropriate affect and was well oriented. Conversation was rational and coherent, and judgment was good.

Since leaving the hospital she has been adjusting very well, enjoying the company of her friends, playing the piano, competing in games, etc. She has worked occasionally when able to get it. Her appetite is good and she sleeps well. Her weight at present is 128 pounds.

Case 2. A twenty-year-old boy was suspicious, apprehensive and catatonic when admitted to the hospital. He had periods of violence and was reacting to auditory hallucinations. His weight at this time was 124 pounds.

His education consisted of a high school course which he completed in five years. A psychological examination gave him an I.Q. of 111.

Insulin treatment consisted of 11 shocks, and the average dose of insulin required to produce shock was 150 units. During shock he perspired profusely and was salivated. His skin was cold and clammy, face was flushed and there were muscular twitchings. Babinski reflex was present. He was tense, active, cyanotic and had generalized convulsions.

After treatment he was friendly, recognized the fact that he had been sick, felt improved; weight was 163 pounds. He was confident and talkative, no longer shy and reticent, and was appreciative of what had been done for him. Following discharge he located work and at the present time is adequately providing for himself.

Case 3. Fear, agitation, irritability, confusion and a feeling of physical inadequacy characterized the symptoms shown by a twenty-two-year-old man at the time of his admission to the hospital. He was disinterested, mute and refused to eat. His

weight was 151 pounds. In school he received very high marks and graduated from high school with honors.

Insulin treatment consisted of 31 hypoglycemic shocks. The average dose of insulin required to produce shock was 200 units. During shock his temperature ranged from 94 to 96. He perspired, was salivated and became cyanotic. He held himself rigidly, rolled his eyes and had generalized convulsions. Left Babinski reflex and ankle clonus were present.

After treatment he was pleasant, cooperative, rational and well oriented. He became interested in his surroundings and neat and tidy in his personal appearance. Weight at the completion of his course of treatment was 165 pounds. Soon after leaving the hospital he obtained a position which enables him to support himself adequately.

Case 4. A young man, twenty-four years of age, was irritable, seclusive, destructive and threatening when admitted to the hospital. He laughed to himself, became upset when questioned, was preoccupied and restless and felt that someone was trying to poison him. He appeared retarded and confused and at times was disoriented. On entering the hospital he weighed 120 pounds. The personal history revealed that he had been a "C" student and that he had left high school when in his second year.

Insulin treatment consisted of 27 hypoglycemic shocks. The average dose required to produce shock was 80 units. During shock his temperature was about 97.4 and his pulse was rapid. He perspired, was salivated, frothed at the mouth and his face was flushed. He held himself tense and rigid, thrashed about and had twitching of the face and extremities. Occasionally he had severe generalized convulsions of the tonic type. At other times, alternating clonic and tonic convulsions were observed. Positive Babinski reflex was also noted.

After insulin therapy his weight was 141 pounds. He became friendly, cooperative and less agitated. At present he is well oriented and fairly alert and is anxious to leave the hospital.

Case 5. When admitted to the hospital, a twenty-four-year-old girl was suspicious, apathetic and retarded and had auditory hallucinations. She misidentified people and thought she had done harm to her family. Most of the time she was preoccupied, asocial and apprehensive. Her weight was 86 pounds. At the age of eighteen she graduated from high school where she had been a good student.

Treatment consisted of 31 hypoglycemic shocks. The average dose of insulin required to produce shock was 80 units. During shock her temperature was sometimes as low as 94. Pulse was of good quality but intermittent. She became cyanotic and had several generalized convulsions. Inability to swallow, profuse perspiration and tremors of the hands and muscles around the mouth were observed. Ankle clonus and nystagmus were present. During the last few shocks a Babinski reflex was noted.

After treatment patient's weight was 104, a gain of 18 pounds. She showed a remarkable improvement in that she was mentally alert, friendly and pleasant and no longer heard voices. Following discharge from the hospital she was given the same position which she had held before the onset of her mental illness. She enjoys doing this work and is making an excellent home adjustment.

Case 6. A man thirty-four years of age, was uncooperative, seclusive, preoccupied and subject to hallucinations when admitted to the hospital for observation. For the most part, he was mute, listless and apathetic. His judgment was poor and he had no insight into his condition. Admission weight was 161 pounds. His education was limited, having completed only grammar school.

Insulin treatment consisted of 51 hypoglycemic shocks. The average dose required to produce shock was 105 units. During shock his temperature averaged 97. He perspired, was salivated and incontinent of urine. His face was flushed and he jerked convulsively. The Babinski reflex was also present.

At the end of the treatment course his weight was 172 pounds. At this time he began to take more interest in his appearance, asked questions about himself and others and helped with the ward work. He conversed readily with others and denied hearing voices.

These patients who have improved will be followed closely over a long period of time. This is essential before any definite conclusions are drawn as to the value of insulin shock treatment of schizophrenia.

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THE PROVIDENCE CHILD GUIDANCE CLINIC

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Function: A clinic for the psychiatric treatment of behavior and personality disorders of childhood, and for consultation in problems of child psychiatry. For children from three to sixteen years of age, whose families cannot arrange for private psychiatric treatment.

Symptomatology of the Behavior Problem: Symptomatology may include any of the usual behavior disorders of childhood, if persistent and not amenable to common sense methods for dealing with them. Such disorders include excessive fear or shyness, negativism, delinquency, school failure in an intelligent child. Physical symptoms for which no physical basis can be determined, such as vomiting, enuresis, soiling and hysterical manifestations, may be included in this group of disorders.

Etiology of Behavior Disorders of Childhood: Aside from those cases in which there exists an organic basis for the disorder, these disturbances have their origin partly in emotional blocking in the child himself, which prevents healthy personality development. Specific methods of therapy are utilized for dealing directly with this emotional blocking. Difficulties in the parent-child relationship and in the child's environmental setting are seen as factors which may also contribute to the child's disturbed condition.

Method of Treatment of Childhood Behavior Disorders — Direct Psychiatric Treatment of the Child: Therapy is carried on in a series of interviews held at regular intervals with the child himself. Duration of treatment varies from a period of several weeks to several months, occasionally longer. Treatment centers on helping the child to segregate the conflicted emotions which contribute toward his difficulty. A specialized technique of interviewing is used, different from any approach used in child-rearing, education or counseling. This specialized technique is different also from any approach utilizing praise, blame, suggestion or reassurance with the child. With young children a specialized type of play interview is set up. In a setting created to permit spontaneous expression, the psychiatrist helps the child to learn to deal with his own emotions more adequately. Many children, usually only those of at least normal intelligence, are able through this type of treatment to bring about healthy changes in behavior. The extent of these changes is determined by the limitations in the child's personality structure and by his environmental setting.

The Clinic's Work with Parents: Parents come to a child guidance clinic for help when good advice about child-rearing fails. This often indicates that such parents may present emotional conflicts about parenthood. These conflicts help to create an unhealthy parent-child relationship and to precipitate behavior difficulties in a child. Through discussions with a trained psychiatric social worker at the clinic, a parent can work toward a clarification in his disturbed feeling and thinking about his relation to his child. This often serves to bring about healthy changes in the parent's behavior toward the child.

Procedure for Arranging for Clinic Treatment for a Child: Patients are referred to the Clinic by the parents or by some individual having responsibility in a particular phase of the child's life, as a teacher, social worker, court worker or physician. One or both parents come to the clinic first to describe the problem. If the situation is one in which psychiatric diagnosis or treatment is indicated, the parent arranges with the psychiatric social worker for the child's appointments with psychiatrist and psychologist for examination. The parent makes arrangements for treatment appointments for the child if, after examination, psychiatric treatment seems advisable. The parent is asked to obtain a complete physical examination of the child by his own physician or clinic before the child has these appointments. Any required physical treatment is left in the hands of the physician or clinic consulted.

Consultations About Children Presenting Behavior Problems: Workers in social agencies, educational and health organizations utilize consultations at the clinic for help in dealing with a child presenting difficulties in behavior. Parents and other interested individuals utilize consultations about the advisability of recommending or planning for psychiatric treatment for a child, in cases in which diagnosis of the problem can be facilitated in this way.

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SPECIAL NUMBER

The JOURNAL is indebted to Dr. Charles P. Fitzpatrick of Butler Hospital, for collecting the papers which appear in this special number. The objection which has been expressed to special numbers of a publication intended to interest general practitioners, cannot hold for the subject of Mental Health. As long as the population of our hospitals for mental diseases continues its increase, Mental Health will be a topic of interest, not only to the psychiatrist, but also to the general practitioner, even to the layman, who finally must pay the bill. There also may be an advantage in the unity of a collection of papers dealing with various phases of a single subject, when compared with the scattered interest of a heterogeneous assortment.

MENTAL HEALTH

Those of us who are especially interested in mental disease are gratified that a special number of the JOURNAL is being devoted to this topic. It seems needless to dwell on the prevalence of mental disturbances of a minor and major nature, or to emphasize the social and economic loss resulting from such disturbances. The hospital accommodation necessary to house patients in the United States suffering from major mental disorders is a matter of common knowledge. A ray of hope, however, is present here and there in the picture. The recently developed techniques of treating dementia praecox by insulin shock and artificially induced convulsions indicates a new emphasis on the medical approach to this problem. Neither of these two methods of treatment supplies the complete answer to the treatment of this disorder. They do, however, indicate that considerable thought is being devoted to the biochemical and physical approach to mental disease, and should be productive of much further work along similar lines.

Another concept which is receiving increased attention in the medical world today is that the individual represents the integrated function of all his organ systems, and that he can not be considered, when he is ill, as merely suffering from disturbed function of one or two systems. Every physical disability has its mental component. Studies and experience have demonstrated that this component cannot be neglected if the best results in treatment are to be achieved.

Conversely, mental disturbances frequently result in physiological dysfunction of various somatic structures. Admittedly, our knowledge of psychosomatic relationships is still limited, but a great opportunity for investigation and original work is open in this field. Investigation along these lines can fortunately be carried on without the aid of an elaborate technical laboratory. Careful observation and accurate recording are all that are necessary. The field is open to all engaged in the practice of medicine.

Dr. Harvey Cushing, an eminent authority, has said that there is often a definite relationship between conditions such as gastric ulcer and the emotional status of the patient. It is well known, also, that spastic and mucous colitis is frequently associated with an emotional maladjustment. The general practitioner is in a particularly fortunate position insofar as the correlation of physical and mental disorder is concerned. He sees the cases early and is in a position to apply remedial measures before the pattern has become too set. It is generally conceded that no matter what treatment of mental disturbances is adopted, the earlier it is begun the more satisfactory are the results.

In view of the strides which have been made forward in the field of mental disease in the past twenty years, and the increasing interest which is being manifested by the profession at large, there is every reason to feel that progress in this particular branch of medicine will continue at a rapid rate.

Memorial Hospital

A Clinical Pathological Conference was held Wednesday, January 12. The first case introduced was a carcinoma of the esophagus, presenting unusual difficulties in diagnosis. The case was presented by Dr. Jacob Greenstein and Dr. John F. Kenney from the medical service. The second case, which was presented by Dr. John F. Kenney and Dr. Thad. Krolocki, was a bacterial endocarditis with presentation of specimens, lantern slides, and charts. These cases were discussed by the various members of the staff.

NOTE: A new projector and microscopic photographic apparatus has been added to the hospital equipment, thus making the various clinical conferences and staff meetings more complete.

Dr. Durtad R. Baronian has received an appointment to the medical service of the Boston City Hospital, starting July 1, 1938.

Woonsocket Hospital

The December meeting of the Woonsocket Hospital Regular Staff was held on Monday, the 13th, with Dr. T. Frank Kennedy presiding. Dr. P. James O'Brien read a paper in the form of a report on "The Stillbirth and Infant Mortality for Woonsocket in 1936 as Compared with Statistics for 1925." A review of a case of perforated ulcer of the stomach was presented by Drs. F. J. King and N. S. Garrison.

On January 10, 1938, the Regular Staff of the Woonsocket Hospital held its annual meeting. The following officers were re-elected:

President: Dr. T. Frank Kennedy

Vice-President: Dr. Henri E. Gauthier

Secretary-Treasurer: Dr. Thomas J. Lalor

Dr. George Crepeau was elected to membership on the staff. A paper was read by Dr. J. T. Roswell on "Neuro-Circulatory Asthenia." The discussion was opened by Dr. William King.

RHODE ISLAND ASSOCIATION OF RECORD LIBRARIANS

The regular monthly meeting of the Rhode Island Record Librarians' Association was held on Tuesday, January 18, 1938, at 3:30 P. M., at the Medical Library, Francis Street, Providence. Dr. Albert H. Miller presented an interesting paper on "The Value of Records".

Dr. Miller spoke of the value of keeping good hospital records, the necessary information that should be incorporated in them, and the various systems that are used in the handling of charts. He cited an instance where, if records had been kept at the time, the patient and doctor would have at a later date benefited very much by the information contained therein. Dr. Miller emphasized the advantages of being able to compile statistics within a short period of time. He also spoke of the value of statistics for a person doing research work. At the conclusion of his paper, Dr. Miller kindly answered questions which were asked by the members. The Meeting adjourned at 5:00 P. M.

Rhode Island Hospital

SCHEDULE FOR
FEBRUARY, 1938

Thursday, February 3, 1938
Gyn Staff Meeting, 8:30 P. M.
Friday, February 4, 1938
G. U. Staff Meeting, 7:30 P. M.
Surgical Staff Meeting, 8:30 P. M.
Tuesday, February 8, 1938
Clinical Path. Conference, 12:00 noon
Tuesday, February 22, 1938
Clinical Path. Conference, 12:00 noon
Mondays
Surgical Grand Rounds, 10:00 A. M.
I Surgical Grand Rounds, February 14, 28
II. Surgical Grand Rounds, February 7, 21
Thoracic Clinic, 4:30 P. M.
Tuesdays
Gastro-Intestinal Clinic, 9:30 A. M.
Surgical Grand Rounds, 10:00 A. M.
I Surgical Grand Rounds, February 8, 22
II Surgical Grand Rounds, February 1, 15
Wednesdays
Tumor Clinic, 10:00 A. M.
Note: The Skin Clinics have been temporarily discontinued
Thursdays
Orthopedic Grand Rounds, 9:00 A. M.
Thoracic Clinic, 11:30 A. M.
Fridays
Fracture Grand Rounds, 11:00 A. M.
Pediatric Grand Rounds, Feb. 11, 25, 11 A.M.
Saturdays
Neurological Grand Rounds, 9:00 A. M.
Medical Conference, 10:00 A. M.

MEMORABILIA

December 13, 1937

Dr. Walter C. H. Weigner presided at a meeting of the Rhode Island Society for Neurology and Psychiatry, held at the Charles V. Chapin Hospital. Dr. Hugh E. Kiene presented "Insulin Shock Treatment in Schizophrenia." He showed a patient in insulin shock and several remarkable recoveries following this treatment. The subject was discussed by Drs. Fitzpatrick and McDonald.

January 12

Dr. George W. Matteson entertained the Amos Throop Club. Dr. Frank B. Cutts, guest speaker, chose as his subject, "A Discussion of Blood Chemistry." The paper was discussed by Drs. Kingman, William B. Cutts, Brackett, Wells, Ham, and members of the club.

January 13

The regular monthly meeting of the Staff Association of St. Joseph's Hospital was held at the Nurses' Auditorium at 8:30 P. M. Dr. Vincent J. Oddo presented a paper on "Urological Problems." Collation was served.

January 14

Dr. Niles Westcott entertained the William W. Keen Medical Club. The title of his paper was "Traumatic Psychoneuroses." Dr. Russell Bowman was elected a member of the club, increasing the total membership to nineteen.

January 17

The Thirty-four Medical Club met with Dr. Charles Bradley.

January 18

At the regular monthly meeting of the General Staff of the Homeopathic Hospital of Rhode Island, Dr. Samuel Morein read a paper on "The Medical Management of Gastric and Duodenal Ulcers." Luncheon followed.

January 21

Dr. Arthur H. Ruggles entertained the Friday Night Medical Club at Duncan Lodge. He read a paper on "Observations on Insulin Treatment of Schizophrenia."

January 24

Dr. Charles A. McDonald entertained the Providence Medical History Club. His subject was "Medical History of Aneurism."

January 27

The regular quarterly meeting of the Rhode Island Medico-Legal Society was held at the Medical Library at 5:00 P. M. Honorable Charles A. Walsh, Associate Justice of the Rhode Island Superior Court, addressed the meeting on the subject:—"Psychiatry and Criminal Law." Supper was served following adjournment.

The officers of the American Public Health Association announce that the 67th Annual Meeting will be held in Kansas City, Mo., October 25-28, 1938. Dr. Edwin Henry Schorer, Director of the Kansas City Health Department, has been appointed Chairman of the Local Committee. He will be assisted by a large group of city and state officials and community leaders.

A long list of affiliated organizations meet habitually with the American Public Health Association. They include: The American Association of School Physicians, The Association of Women in Public Health, The Conference of State Laboratory Directors, The Conference of State Sanitary Engineers, The American Association of State Registration Executives, Delta Omega, The International Society of Medical Health Officers. The attendance at the 67th Annual Meeting will exceed 3000 professional public health workers from every State in the Union, Canada, Cuba and Mexico.

AMERICAN BOARD OF INTERNAL MEDICINE

The American Board of Internal Medicine will hold its next written examination on Monday, February 14, 1938, in various centers of the United States and Canada. The Examination will consist of two sessions of three hours each with the morning session held at 9:00 o'clock and the afternoon session at 2:00 o'clock. The candidates who are successful in this written examination will be eligible to take the practical examination which will be held in San Francisco on Friday and Saturday prior to the opening of the Annual Session of the American Medical Association in June, 1938.

The final date for filing applications for this written examination is January 15, 1938. For further particulars and application blanks, address Walter L. Bierring, M.D., Chairman, American Board of Internal Medicine, 1210, 406 Sixth Avenue, Des Moines, Iowa.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next examination (written and review of case histories) for Group B candidates who have filed applications will be held in various cities of the United States and Canada, on Saturday, February 5, 1938. The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, California, on June 13, and 14, 1938, immediately prior to the meeting of the American Medical Association. Applications for admission to the June 1938 Group A examination must be on an official application form and filed in the Secretary's Office before April 1, 1938. For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pa.

"THE FOUNDATION PRIZE" OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNECOLOGISTS AND ABDOMINAL SURGEONS

(1) "The award which shall be known as 'The Foundation Prize' shall consist of $500.00."

(2) "Eligible contestants shall include only (a) interns, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M. D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal surgery."

(3) "Manuscripts must be presented under a nom-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the nom-de-plume and containing a card showing the name and address of the contestant."

(4) "Manuscripts must be limited to 5000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis."

(5) "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the Author's choice. Unsuccessful contributions will be returned promptly to their authors."

(6) "All manuscripts entered in a given year must be in the hands of the Secretary before June 1st."

(7) "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation."

(8) "The President of the Association shall annually appoint a Committee on Award, under its own regulations, shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

Jas. R. Bloss, M. D., *Secretary.*
418 Eleventh Street,
Huntington, W. Va.

RECENT BOOKS

The Mind of Man. By Walter Bromberg, M.D., pp. 307 with 16 illustrations. Cloth, $3.50. Harper and Brothers, New York and London, 1937.

This attractively written history of the treatment of mental disease is announced as "A work of scientific authority for the layman." The volume, while a serious work, is replete with quotations and anecdotes and the author deserves praise for his clear presentation and the avoidance of technical psychiatric terms. In so comprehensive a work it is unavoidable that the author emphasize such aspects of the history of psychotherapy as he personally thinks are most important. After reviewing the early domination of religion and superstitions in the field of mental treatment, Dr. Bromberg stresses the introduction of suggestion and hypnosis as methods of treatment, and concludes with four chapters on treatment along psychoanalytic lines. There will undoubtedly be differences in opinion as to whether a discussion of psychoanalysis should occupy so important and lengthy a portion of the book. Dr. Bromberg has furnished not only the psychiatrist but also the layman and general medical reader with a work which is both entertaining and informative.

Charles Bradley, M.D.

Why We Do It. An Elementary Discussion of Human Conduct and Related Physiology. By Edward C. Mason, M.D., Ph.D., F.A.C.P., Cloth, $1.50, St. Louis, The C. V. Mosby Company, 1937.

In this book of 177 pages a teacher of physiology looks at human behavior Dr. Mason first presents the problem, then discusses development, normal mechanisms, personality types, "sane and insane," and treatment. The endocrine and autonomic nervous systems are not neglected. He covers briefly and somewhat critically the outstanding

problems of mental disease. The psychologist he handles without marked respect, but one is pleased that the physiologist is demanding his own.

This work emphasizes, as expected, the study of the somatic aspect of behavior, as well as the effects of situation, and of the personality type. Brief notes of cases are added for emphasis and clearness.

This book as a whole is an outline and an introduction, and is necessarily very brief. We hope that the author will see fit to continue this into a fuller work.

NILES WESTCOTT, M.D.

THE TECHNIC OF LOCAL ANESTHESIA. By Arthur E. Hertzler, A.M., M.D., Ph.D., LL.D., F.A.C.S. Sixth Edition, pp. 284, with many illustrations, Cloth, $5.00, The C. V. Mosby Company, St. Louis, 1937.

Local Anaesthesia is a 277 page book, containing numerous excellent illustrations, and describing in brief, lucid detail the neuro-anatomy and technique of local anaesthesia in every operation where local anaesthesia might be of value. It is written in a delightful informal way; it is brief; and it makes interesting, as well as instructive reading.

This book, the sixth edition in 21 years, could only have been written by a surgeon of wide experience. The indications and contra-indications, advantages and disadvantages of local anaesthesia as applied to various surgical procedures as clearly recognized and stated. The underlying neuro-anatomy and the technique are described in simple terms, without confusing detail, but also without important omissions. The author insists on a well planned procedure, and one feels as he reads the text that theory has been brushed aside, and that each problem is viewed from the standpoint of practicability to the surgeon and comfort to the patient.

As a guide to the beginner in surgery, Dr. Hertzler's book should prove invaluable. It is the best short work on this subject I have had the privilege of reading, and I can recommend it highly to any surgeon who does not enjoy the services of an expert regional anaesthetist.

ROBERT R. BALDRIDGE, M.D.

MENTAL THERAPY, STUDIES IN FIFTY CASES. By Louis S. London, M.D., Formerly Passed Assistant Surgeon (R) United States Public Health Service. Two volumes, pp. VIII + 744, with charts and diagrams. Cloth, $12.50. Covici, Friede, 432 Fourth Avenue, New York, 1937.

In this monumental work, the author outlines the evolution of psycho-therapeutics from Plato to Freud. After introductory chapters on psychoanalysis, the meaning of dreams, if any, and the sexual psychology of the child and of the sexual instinct, he gives in detail the psychoanalysis of fifty cases, grouped as hysterical and anxiety neuroses, occasional neuroses, incipient schizophrenia, cyclic neuroses. London's frequent parenthetical comment on these cases is interesting and enlightening. These volumes are offered as an important reference work for psychologists, neurologists, psychiatrists and general practitioners, who may find the cases presented of inestimable value in their practice.

CONCEPTS AND PROBLEMS OF PSYCHOTHERAPY. By Leland E. Hinsie, M.D., Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University, New York. pp. XV + 199. Cloth, $2.75. Columbia University Press, New York, 1937.

Today the psychiatrist must be cognizant of current psychotherapeutic theories and practices and must make up his mind how far his research policies should be dominated by any one method and in what classes of clinical material he should focus his attention for the good of his patients. Hinsie does not attempt to provide proof of the validity of any particular school of psychological training. He has made an honest assay of the applications of psychological knowledge to various fundamental problems of psychiatry.

Although the material is oriented in therapy, the author has presented much more. In fact he has given an evaluation of psychiatric methods of study and of current concepts of the mind. His work must be recognized as an attempt to gain a comprehensive view of the facts in a field much too extensive to be exclusively monopolized by one method of investigation. Physicians and students who are making serious efforts to understand the development and applications of psychotherapy, and to get to the roots of the situation, will find this book a welcome guide, formulated from a wide background of experience.

METHODS OF TREATMENT. By Logan Clendening, M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas. Sixth Edition, pp. 875, Cloth, $10.00. The C. V. Mosby Company, St. Louis, 1937.

The author's justification for this work is very ingeniously explained in the opening sentence in the preface which reads as follows: "The book was planned to furnish an outline of all the methods of treatment in internal medicine." The reviewer feels that the author accomplished all of this admirably. One wonders with amazement, and indeed with gratitude, at the author's ingenuity to cram into one volume of twenty-five chapters so much valuable and useful information. The book serves as a short cut to the busy practitioner, who is ever anxious to find the necessary and authoritative information when he needs it, without having to wade through systems of medicine, special reference books, and voluminous literature. Here in this volume he can obtain the information desired in simple, direct language, briefly and vigorously put.

In the opening chapters we are introduced to the various methods of Therapy, such as rest, drugs, vaccines, serums, etc. The essential drugs like digitalis, salvarsan, quinidine and the anaesthetics are discussed in detail. Drugs of minor importance are less critically evaluated. The chapters on "Endocrinology and Dietetics," although meagre in detail, are very helpful. The chapters dealing with the various technics and procedures, such as spinal puncture, pneumothorax, blood transfusions, etc., are very illuminating and instructive and where necesssary adequately illustrated. The many other subjects discussed in this volume are well chosen and equally as informative. Truly "Methods of Treatment" deserves a special place in every practitioner's ready reference library.

LOUIS I. KRAMER, M.D.